

8067

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Herbert Darius Allen</u> First Middle Last				4. DATE OF DEATH <u>July 30</u> Month Day Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March, 9, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>		11. BIRTHPLACE (State or foreign country) <u>Detroit, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Harvey Allen</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-34-0534</u>		17. INFORMANT <u>Thelma V. Allen</u> Address <u>Joppa, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } DUE TO <u>Arteriosclerosis</u> (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1955</u> to <u>July 1960</u> , that I last saw the deceased alive on <u>July 30, 1960</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>7-30-60</u>			
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>				<u>Kingsville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs</u> ADDRESS <u>Abingdon, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6042

[Faint, mostly illegible handwritten text, likely containing personal and medical details.]

[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or official statement.]

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8049
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH
08025

1. PLACE OF DEATH a. COUNTY HARFORD MAYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MAYLAND b. COUNTY HARFORD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Virgil Binns		4. DATE OF DEATH Month Day Year July 27 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin P. Binns		14. MOTHER'S MAIDEN NAME Minnie Carlton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Address 204 Rogers St. Abiah H. Binns, Aberdeen, Maryland	
17. INFORMANT Abiah H. Binns, Aberdeen, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 526 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic bronchitis and emphysema DUE TO (c) 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis; Coronary atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20 1960 to July 28 1960 that (I) (we) last saw the deceased alive on July 28 1960 , and that death occurred at 3:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett Jr. M.D.		22b. DATE SIGNED 7-28-60	
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D.		22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR AUG 1 '60 25b. REGISTRAR'S SIGNATURE Charles L. Hume	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8068

CERTIFICATE OF DEATH

Reg. Dist. No.

08026

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville, Md.</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Alcesta</u> Last <u>Boring</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1899</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Simon O. Strunk</u>				14. MOTHER'S MAIDEN NAME <u>Florence Poff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Maurice Boring Jarrettsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardiovascular-Renal disease</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u> <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 1957</u> to <u>July 5, 1960</u> , that I last saw the deceased alive on <u>June 25, 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>July 5, 1960</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				FOREST HILL, MD.			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>				FOREST HILL, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/8/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kuntz</u>				ADDRESS <u>Jarrettsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>			

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8050

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08027

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>HARFORD</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE DE GRACE</i>				c. LENGTH OF STAY IN 1b <i>32 DAYS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HARFORD MEMOCIAL Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>MARGIE J</i> Middle <i>BOWSER</i> Last <i>BOWSER</i>				4. DATE OF DEATH Month <i>JULY</i> Day <i>7</i> Year <i>1960</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/27/1931</i>	
9. AGE (In years last birthday) <i>28</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ROLAND E. LUKE</i>				14. MOTHER'S MAIDEN NAME <i>GLADYS LEAR</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Hosp. Records Harde Shaw, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Infarction, right</i> DUE TO <i>Rheumatic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Decompensation</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 weeks</i> <i>11 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>June 5th, 1960</i> to <i>July 7th, 1960</i> that (I) <i>was</i> last saw the deceased alive on <i>July 7th, 1960</i> and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Edward C. Loo, M.D.</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/8/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>EDWARD C. LOO, M.D.</i>				22d. ADDRESS <i>211N. Union Ave, Haure de Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/12/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ham Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Martinsburg Pa. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home, Harde Shaw, Md.</i>				25a. REC'D BY REGISTRAR <i>Arthur L. Hines</i>		25b. REGISTRAR'S SIGNATURE	
25c. DATE <i>JUL 14 '60</i>							

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(M)

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(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8051

08028

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>RD Box 228</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bryan</u> First <u>BROWN</u> Middle Last				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3 1960</u>	
9. AGE (If years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTH PLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GERALD Thomas BROWN</u>				14. MOTHER'S MAIDEN NAME <u>MARY Louise LSCNNOCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Gerald F. Brown</u> Address <u>Darlington MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LACERATION of TESTICULUM</u> DUE TO (c) <u>PATENT DUCTUS ARTERIOSUS</u> INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity of Visceral Organs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 3</u> 19 <u>60</u> , to <u>July 5</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>60</u> , and that death occurred at <u>8:50</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>				22d. ADDRESS <u>Darlington, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>July 7, 1960</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Franklin Ave.</u>		23d. LOCATION (City, town, or county) (State) <u>Harford Co., MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. Bailey</u>				ADDRESS <u>Darlington, MD</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 8 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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8031

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8069

CERTIFICATE OF DEATH

08029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylor</u>				c. LENGTH OF STAY IN 1b <u>7 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Monkton Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELWOOD MORRIS CALARY</u>				4. DATE OF DEATH Month Day Year <u>July 27 1960</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28-1865</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Renova Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>PETER FRANCIS CALARY</u>				14. MOTHER'S MAIDEN NAME <u>EDITH BARBER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Monkton Md.</u> <u>MRS ERNEST B. GARRISON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 month</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>55</u> , to <u>27 July</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>26 July</u> , 19 <u>60</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. R. E. Mosley</u> M.D.				ADDRESS (Street, city or town, state) <u>Jarrettsville Md.</u>		DATE SIGNED <u>7/28-60</u>	
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Madonna Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Kunk</u>				ADDRESS <u>Jarrettsville Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 1 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

8000

1. NAME OF DECEASED <i>JOHN W. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1910</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocarditis</i>		9. PERIOD OF ILLNESS <i>2 weeks</i>	
10. OCCASION OF DEATH <i>While at work</i>		11. PLACE OF BIRTH <i>MD</i>		12. DATE OF BIRTH <i>Jan 1 1865</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF FUNERAL HOME <i>None</i>		15. NAME OF BURIAL PLACE <i>None</i>	
16. NAME OF WITNESS <i>John W. Smith</i>		17. NAME OF WITNESS <i>John W. Smith</i>		18. NAME OF WITNESS <i>John W. Smith</i>	
19. NAME OF WITNESS <i>John W. Smith</i>		20. NAME OF WITNESS <i>John W. Smith</i>		21. NAME OF WITNESS <i>John W. Smith</i>	
22. NAME OF WITNESS <i>John W. Smith</i>		23. NAME OF WITNESS <i>John W. Smith</i>		24. NAME OF WITNESS <i>John W. Smith</i>	
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52. NAME OF WITNESS <i>John W. Smith</i>		53. NAME OF WITNESS <i>John W. Smith</i>		54. NAME OF WITNESS <i>John W. Smith</i>	
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79. NAME OF WITNESS <i>John W. Smith</i>		80. NAME OF WITNESS <i>John W. Smith</i>		81. NAME OF WITNESS <i>John W. Smith</i>	
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94. NAME OF WITNESS <i>John W. Smith</i>		95. NAME OF WITNESS <i>John W. Smith</i>		96. NAME OF WITNESS <i>John W. Smith</i>	
97. NAME OF WITNESS <i>John W. Smith</i>		98. NAME OF WITNESS <i>John W. Smith</i>		99. NAME OF WITNESS <i>John W. Smith</i>	
100. NAME OF WITNESS <i>John W. Smith</i>		101. NAME OF WITNESS <i>John W. Smith</i>		102. NAME OF WITNESS <i>John W. Smith</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. DISEASE OR INJURY
9. PERIOD OF ILLNESS
10. OCCASION OF DEATH
11. PLACE OF BIRTH
12. DATE OF BIRTH
13. NAME OF PHYSICIAN
14. NAME OF FUNERAL HOME
15. NAME OF BURIAL PLACE
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102. NAME OF WITNESS

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8041

08030

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>27 Hanover Street</i>				d. STREET ADDRESS <i>1 27 Hanover St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Norman</i> Middle <i>C.</i> Last <i>Christy</i>				4. DATE OF DEATH Month <i>7</i> Day <i>30</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 27, 1900</i>	9. AGE (In years last birthday) <i>59 yrs.</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>30</i> Hours <i>19</i> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A. P. Ground</i>		11. BIRTHPLACE (State or foreign country) <i>Perryman, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Benjamin C. Christy</i>				14. MOTHER'S MAIDEN NAME <i>Mary C. Christy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Edward Holland, Harford, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lung Abscess</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i> (c) <i>Pneumonia</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>o. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 28</i> 1960 to <i>7/30</i> 1960, that (I) (we) last saw the deceased alive on <i>7/30</i> 1960, and that death occurred at <i>8:30 A.</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>George T. Stansbury</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/30/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				22d. ADDRESS <i>569 Revolution Street Harford, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-3-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Aberdeen Harford Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Bullock, Harford, Md.</i>				ADDRESS <i>556 Lewis St.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur J. Kline</i>	
				25a. REC'D BY REGISTRAR DATE <i>AUG 2 '60</i>			

(M)

X

(1)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8052

CERTIFICATE OF DEATH

08031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. LENGTH OF STAY IN TB <i>60 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		d. STREET ADDRESS <i>833 Juniata</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Annie Coccia DiVincentis</i>		4. DATE OF DEATH <i>7/18/60</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/36/1888</i>	
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Edith Bungori</i>		Address <i>833 Juniata Rd. Harford Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Glomerulonephrosis</i> (c) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 year</i> <i>20 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March, 1960</i> to <i>July, 1960</i> , that I last saw the deceased alive on <i>July 17, 1960</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>200 W. Union Ave Harford Md</i> DATE SIGNED <i>7/20/60</i>			
ACTUAL SIGNATURE <i>Norman Berger</i>		M.D. <i>Norman Berger M.D.</i>	
PHYSICIAN'S NAME (Type) <i>Norman Berger</i>		M.D. <i>7/20/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7/21/60</i>		22b. DATE THEREOF <i>7/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Not Christian</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emory R. Roy</i>		ADDRESS <i>Harford Md.</i>	
24a. REC'D BY REGISTRAR <i>Jul 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles P. House</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8053
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08032

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 1 Rt 2 Box 829		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard First J Middle DORAN Last Sr.				A. DATE OF DEATH July Month 20 Day 1960 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Jan. 23, 1888	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,			
13. FATHER'S NAME Richard DORAN				14. MOTHER'S MAIDEN NAME Rosanna Kahoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-26-3036		17. INFORMANT Carl A. Doran Address Joppa, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C V Disease DUE TO (c) Chronic & decompensated C V Disease						INTERVAL BETWEEN ONSET AND DEATH 8 das 6 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-12- 1960 to 7-20 1960 , that (I) (we) last saw the deceased alive on July 19, 1960 , and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE J. Ralph Horky				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July, 20, 1960	
22c. PHYSICIAN'S NAME (Type) J. Ralph Horky				22d. ADDRESS Churchville, Harford Co., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 23, 1960		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		23d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCormack				ADDRESS Abingdon, Maryland.		25a. REC'D BY REGISTRAR DATE JUL 25 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1973



DATE OF DEATH 2/15/73

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8054

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08033

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> b. COUNTY <u>WOODBURY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbury</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		d. STREET ADDRESS <u>Broad St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christina E.</u> First Middle Last		4. DATE OF DEATH <u>7</u> Month <u>30</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1889</u> yrs.
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSE</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BARWICK</u>		14. MOTHER'S MAIDEN NAME <u>MARY KEARNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>172 226133</u>	
17. INFORMANT <u>Carmel Fisher</u> Address <u>Ship Bottom, N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A. S. C. V. D.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>July 30th 1960</u> to <u>July 30th 1960</u> that (I) (we) last saw the deceased alive on <u>July 30 1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. ADDRESS <u>211 N. Union Ave. Harre de Grace</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>211 N. Union Ave. Harre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>7/31/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST</u>	23d. LOCATION (City, town, or county) <u>EAST PITMAN, N.J.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington + San Harre de Grace</u>		25a. REC'D BY REGISTRAR <u>WUG 4 '60</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08034

8070

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. LENGTH OF STAY IN 1b <u>73 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>J.</u> Last <u>Flottesmesch</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Heinrich Flottesmesch</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Busch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Joseph H. Flottesmesch</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Smiley</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>60</u> to <u>7/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>60</u> , and that death occurred at <u>4</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D.				ADDRESS (Street, city or town, state) <u>Edgewood, Maryland.</u> DATE SIGNED <u>7/29/1960</u>			
PHYSICIAN'S NAME (Type) <u>E. Louis Kahan</u>				<u>Edgewood, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Balto., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs</u>				ADDRESS <u>Abingdon Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kahan</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8071

CERTIFICATE OF DEATH

08035

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Bel Air		c. LENGTH OF STAY IN 1b 18 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		d. STREET ADDRESS 218 Ridge Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BEULAH ALICE MAE GOETZ		4. DATE OF DEATH Month Day Year JULY 22 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1884
9. AGE (In years last birthday) 60 75		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. DATE OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gloucester Morrell		14. MOTHER'S MAIDEN NAME Harriet Klingensmith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. E. J. Campbell		Address Wheaton, Md. 2318 Blue Ridge Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of COLON 159.8 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH ??
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. cardiovascular disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1959 , to July 22 1960 , that I last saw the deceased alive on July 21 1960 , and that death occurred at 5:30a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson M.D. Forest Hill, Md. 7-22-60			
ACTUAL SIGNATURE Willard P. Hudson			
PHYSICIAN'S NAME (Type) Willard P. Hudson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-25-60	22c. NAME OF CEMETERY OR CREMATORY Prospect	22d. LOCATION (City, town, or county) (State) Brackenridge, Penn.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUL 25 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08036

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md.</u>		c. LENGTH OF STAY IN 1b <u>3 yrs. 7 Mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>		d. STREET ADDRESS <u>Rt. 1 Box 73</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>B.</u> Last <u>Huber</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1867</u>
9. AGE (In years last birthday) yrs. <u>93</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Anna Redding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Records of Harford Convalescent Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion terminating . Chronic Cardio-</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Vascular Disease.</u> DUE TO (c) <u>Advanced Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1956</u> , to <u>July 1960</u> , that I last saw the deceased alive on <u>July 4, 1960</u> , and that death occurred at <u>5:00A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson M.D. Forest Hill, Md. 7/6/60</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson M.D.</u> Forest Hill, Maryland			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> Forest Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-9-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Kingsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kears</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8072
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1b Film G267 7-28-60 et

CERTIFICATE OF DEATH

08037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 394 Singer Rd</u>		d. STREET ADDRESS <u>Box 394 Singer Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Victoria</u> Middle <u>Kilkowski</u> Last <u>Kilkowski</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25 1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Egnatius Kucharzewski</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Frances J. Makowski</u>		Address <u>Singer Rd Edgewood</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP FAILURE</u> DUE TO <u>ANEMIA + GENERAL DEBILITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF BLADDER</u> DUE TO (c) <u>CARCINOMA OF BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 HRS</u> <u>4 MONTHS</u> <u>11 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ADVANCED ARTERIO SCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 Sept</u> 19 <u>56</u> , to <u>18 JULY</u> 19 <u>60</u> , that I last saw the deceased alive on <u>18 JULY</u> 19 <u>60</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.P. Adwell</u>		ADDRESS (Street, city or town, state) <u>1017 Franklin St. Baltimore Md</u>	
DATE SIGNED <u>7/19/60</u>			
PHYSICIAN'S NAME (Type) <u>H.R. SIDWELL M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer cem</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Rd Balto & Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Dippel</u>		ADDRESS <u>Bro. 1800 E. Lombard St</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8073

CERTIFICATE OF DEATH

Reg. Dist. No.

08058

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORRISVILLE</u>		c. LENGTH OF STAY IN 1b <u>14 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>STUART ROBINSON KIRKWOOD</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>20</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 5 1876</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>SHAWSVILLE, MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>ROBERT KIRKWOOD</u>	14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH ROBINSON</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>170-24-2090</u>	INFORMANT <u>MISS. BLANCHE KIRKWOOD</u>	Address <u>STEWARTSTOWN RD 1 PA.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>-15 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>April 10, 1954</u> , to <u>July 20, 1960</u> , that I last saw the deceased alive on <u>July 20, 1960</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.	DATE SIGNED <u>7-22-60</u>
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/23/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>	22d. LOCATION (City, town, or county) (State) <u>MADONNA MD.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Ruiz</u>	ADDRESS <u>Jarrettsville Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Ruiz</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8074

CERTIFICATE OF DEATH

Reg. Dist. No.

08039

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		4. DATE OF DEATH Month July Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1891
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher (Ret.)	
10a. KIND OF BUSINESS OR INDUSTRY Slaughter House		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Kretlow	
14. MOTHER'S MAIDEN NAME Johanna Kaiser		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 213-01-1584		17. INFORMANT Richard Kretlow, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 , to July 16, 1960 , that I last saw the deceased alive on July 15, 1960 , and that death occurred at 3:16AM from the causes and on the date stated above.			
ACTUAL SIGNATURE B. J. Plunkett Jr.		ADDRESS (Street, city or town, state) 617 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D.		DATE SIGNED 7-17-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/60	
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		24a. REC'D BY REGISTRAR DATE JUL 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8075

CERTIFICATE OF DEATH

Reg. Dist. No.

08040

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BEL AIR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) BEL AIR</u>			
c. LENGTH OF STAY IN 1b <u>42YRS</u>				d. STREET ADDRESS <u>Box 198 RD #1 BEL AIR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 198 RD #1 BEL AIR</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL REBECCA LAWTON</u>				4. DATE OF DEATH Month Day Year <u>JULY 6 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 2, 1916</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN F. BLACK</u>				14. MOTHER'S MAIDEN NAME <u>SALLY MAE HALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>214-22-324</u>		17. INFORMANT Address <u>JOHN F. BLACK, RD #1, BEL AIR, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>OVER 1 YEAR</u> <u>OVER 1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBESITY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JULY 2, 1960</u> to <u>JULY 6, 1960</u> , that I last saw the deceased alive on <u>JULY 3, 1960</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Philip W. Heuman M.D. 307 Hickory St. July 6, 1960</u> PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D. BEL AIR, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR HARF. CO., MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8045

CERTIFICATE OF DEATH

Reg. Dist. No. 08041

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>71</u> YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gordon St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Effie F Lee</u>		4. DATE OF DEATH <u>July 30</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert T. Geatty</u>		14. MOTHER'S MAIDEN NAME <u>Mary None-maker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>W. Gordon Street</u> <u>Mr. R. Harry Lee</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-30</u> , 19 <u>59</u> to <u>7-30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-30</u> , 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>7-30-60</u>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 2, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harf. Co, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

Name of Deceased ALFRED T. GEARTY		Sex Male	
Date of Birth 1917		Place of Birth Household	
Date of Death 1952		Place of Death Household	
Cause of Death Heart Disease		Manner of Death Natural	
Occupation None		Usual Residence Household	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Certificate 1952		Place of Issuance Baltimore County, Maryland	

MADE IN U.S.A.

U.S. GOVERNMENT PRINTING OFFICE

1952

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

8055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08042

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Vance</u> Last <u>Lemley</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 31, 1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>6</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired JANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>222-050-012</u>		17. INFORMANT Address <u>C.E. Lemley, 1436 Pacific St., Brooklyn, 16, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Since 7/5/60</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1960</u> to <u>July 6, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1960</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury,</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/6/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Harre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 10, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		23d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McBrat Jr.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1917

(M)

Name

Place of Birth

U.S. GOVT.

10-20-01

20-01

DOCTOR

1

DATE OF DEATH

1917

Page 4 of 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
8056
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08043

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvards Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvards Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS <u>1515 Union Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Bernhardt</u> First <u>(None)</u> Middle <u>Levy</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Levy</u>		14. MOTHER'S MAIDEN NAME <u>Rose Long Link.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. LEONARDE T. TROUT</u> Address <u>HARVARD GRACE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>331X</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> to <u>7-28</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>7-26</u> , 19 <u>60</u> and that death occurred at <u>4:15</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>C. L. Lewis MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Harvards Grace MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-31-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Burial Society</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harvards Grace, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

11-12

CERTIFICATE OF DEATH

7058



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8042

CERTIFICATE OF DEATH

Reg. Dist. No.

08044

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 354 Carter Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle VIOLA Last LILLY		4. DATE OF DEATH Month July Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Simpson		14. MOTHER'S MAIDEN NAME Emily Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 226-14-9300B	
17. INFORMANT Inez Clifton		Address 354 Carter St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general DUE TO (c) Arteriosclerosis general		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1960 , to July 23, 1960 , that I last saw the deceased alive on July 23, 1960 , and that death occurred at 12:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 S. Union Ave. DATE SIGNED ACTUAL SIGNATURE Irvin L. Wachsman, M.D. PHYSICIAN'S NAME (Type) Irvin L. Wachsman, M.D. Harre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/60	
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. 2, Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8057

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80845

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Abingdon</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>839 Erie Street</i>		d. STREET ADDRESS <i>R.F.D.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas Edward Lingham</i>		4. DATE OF DEATH Month Day Year <i>7 11 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 16, 1881</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Service Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Army Chemical Center</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Robert Louis Lingham</i>		14. MOTHER'S MAIDEN NAME <i>Amada A. Norton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>213-14-9175</i>	
17. INFORMANT Address <i>839 Erie St. Harre de Grace, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio renal disease</i> DUE TO (c) <i>Hypertensive Cardio renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/4</i> 1960, to <i>7/11</i> 1960 that (I) (we) lost the deceased alive on <i>7/11</i> 1960, and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>George T. Stansbury</i>		22b. DATE SIGNED <i>7/12/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		22d. ADDRESS <i>569 Revolution St. Harre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-14-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Abingdon Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E Bullock</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 15 '60</i>	
ADDRESS <i>Harre de Grace, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

JUL 15 '60

1891

MARYLAND STATE DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH OFFICER
Baltimore, Maryland
CERTIFICATE OF DEATH

8077

(M)

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain details about a death, including names, dates, and locations.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

8058

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08046

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN lb <u>9 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
4. DATE OF DEATH Month <u>JULY</u> Day <u>15</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen KATE KALKMAN LORD</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/90</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months <u>69</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE-Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illustrator</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER KALKMAN</u>		14. MOTHER'S MAIDEN NAME <u>HELEN TRONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>218-26-3077</u>	
17. INFORMANT <u>RUSSELL R. LORD.</u>		Address <u>Bel Air Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Deкомпensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1960</u> to <u>July 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 15, 1960</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE <u>7/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD C. LOO, M.D.</u>		22d. ADDRESS <u>2111 Union Ave., Haver de Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>July 15, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Loo</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 20 '60</u>	
ADDRESS <u>Abingdon, Md.,</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

8052

10-10-68

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8046

CERTIFICATE OF DEATH

Reg. Dist. **08047**

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Melvina</u> Middle <u>McCleary</u> Last <u>McCleary</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry McCleary</u>			
14. MOTHER'S MAIDEN NAME <u>Mary McQuirk</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Convalescent Home Records.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-Vascular Disease</u> DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>July</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>July 7, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>				<u>Forest Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-9-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKendree</u>		22d. LOCATION (City, town, or county) (State) <u>Airville, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Penna.</u>				24a. REC'D BY REGISTRAR <u>Jul 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneib</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08048

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Shamokin</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shamokin</u>		
c. LENGTH OF STAY IN lb <u>-</u>			d. STREET ADDRESS <u>1319 Fern St</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>					
3. NAME OF DECEASED (Type or print) <u>John J. McCracken</u>			4. DATE OF DEATH <u>July 12 1960</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan 6 - 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>6</u> Days	
11. BIRTH PLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker (Self emp)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pool</u>		
13. FATHER'S NAME <u>Frank McCracken</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Lowday</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>178-05-0365</u>		17. INFORMANT <u>Farrow Funeral Directors - 6th & Chestnut</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-13-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North's Memorial Park</u>	
22d. LOCATION (City, town, or country) (State) <u>Shamokin - Penna.</u>		23. FUNERAL DIRECTOR <u>John G. Barring Aberdeen, Maryland</u>			
24a. REC'D BY REGISTRAR <u>John G. Barring</u>		24b. REGISTRAR'S SIGNATURE <u>John G. Barring</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8060

CERTIFICATE OF DEATH

Reg. Dist. No.

08049

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamden Chase</i>		c. LENGTH OF STAY IN TB <i>40 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Flora</i> First <i>Cocci</i> Middle <i>Morette</i> Last		4. DATE OF DEATH <i>7/26/60</i> Month <i>7</i> Day <i>26</i> Year <i>19</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/2/1886</i>
9. AGE (in years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTH PLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i> ✓	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Joseph Morette</i> Address <i>406 N. Stokes</i>		18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Coma</i> <i>581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cirrhosis of the liver</i> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Aug. 16</i> , 19 <i>55</i> to <i>July 26</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>July 26th</i> , 19 <i>60</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward C. Loo</i> M.D.		ADDRESS (Street, city or town, state) <i>211 N. UNION AVE. HAVRE DE GRACE, MD.</i>	
DATE SIGNED <i>7/27/60</i>			
PHYSICIAN'S NAME (Type) <i>DR. EDWARD C. LOO</i>			
22. BURIAL, CREMATION, REMOVAL (Specify) <i>7/29/60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Ann</i>		22d. LOCATION (City, town, or county) <i>Hamden Chase Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William L. Harris</i>		ADDRESS <i>Hamden Chase Md.</i>	
24a. REC'D BY REGISTRAR <i>William L. Harris</i>		24b. REGISTRAR'S SIGNATURE <i>William L. Harris</i>	
DATE <i>AUG 1 '60</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8076

CERTIFICATE OF DEATH

Reg. Dist. No. 08050

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b 26 yrs.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle C Last Morgan		4. DATE OF DEATH Month July , Day 11 , Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 17, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Conn.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME George S. Morgan		14. MOTHER'S MAIDEN NAME Esther Morey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-32-5706	
17. INFORMANT Thomas F. Morgan		Address White Marsh, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Measenteric Thrombosis DUE TO Intensified C. V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 422.1 Measenteric Thrombosis DUE TO Intensified C. V. Disease (c) 422.1 Measenteric Thrombosis DUE TO Intensified C. V. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cellulitis, left side of face INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 11, 1960 to July 12, 1960 , that I last saw the deceased alive on July 11, 1960 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Arky		DATE SIGNED July 12	
PHYSICIAN'S NAME (Type) F. Ralph Arky MD		ADDRESS (Street, city or town, state) Churchville	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Emmorton, Harford, Ms.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConner		ADDRESS Abingdon, Md.,	
24a. REC'D BY REGISTRAR JUL 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2500

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08051

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hartford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre-de-Grace</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hartford Memorial Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WARTINGTON</i>			
f. STREET ADDRESS <i>R. D. #2 Box 120</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Grace E. Norman</i>				4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-7-1899</i>	
9. AGE (In years lost birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Army Chemical Center</i>			
11. BIRTHPLACE (State or foreign country) <i>N. C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Floyd Choate</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>220-22-0677</i>			
17. INFORMANT <i>Edith D. Norman</i>				Address <i>Daughter</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Coma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Breast with Metastases</i> DUE TO (c) <i>Carcinoma of Breast with Metastases</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>170X</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June 24, 1960</i> to <i>July 6, 1960</i> , that (I) (we) last saw the deceased alive on <i>July 6, 1960</i> , and that death occurred at <i>10:00 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>George T. Stansbury</i>				22b. DATE SIGNED <i>7/6/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>				22d. ADDRESS <i>569 Revolution St. Harre de Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-10-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Jarrettsville, Hartford Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>				25a. REC'D BY REGISTRAR <i>Arthur S. Hines</i>			
ADDRESS <i>Harre de Grace, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

100

STATE OF TEXAS
COUNTY OF DALLAS

100

(M)

(F)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08052

8043

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 3 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 N. Phila. Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OWEN Middle PERCIVAL Last OSBORN				4. DATE OF DEATH Month July Day 5 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 60		IF UNDER 24 HRS. Months 5 Days 19 Hours 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Luther Stewart Osborn				14. MOTHER'S MAIDEN NAME Sarah Rebecca Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X				16. SOCIAL SECURITY NO. 212-12-5085			
17. INFORMANT Bertie Osborn, Aberdeen, Md.				Address 21 N. Phila. Blvd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, (Heart Attack) DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 , 19____, to June 16 , 19 60 , that I last saw the deceased alive on July 2 , 19 60 , and that death occurred at 4:30 PM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 114 W. Bel Air Ave. DATE SIGNED _____							
ACTUAL SIGNATURE Andre' Weiss M.D.				PHYSICIAN'S NAME (Type) Andre' Weiss M.D. Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home Aberdeen, Md.				24a. REC'D BY REGISTRAR DATE JUL 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8077

08053

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, R.D.,</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Singer Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Geraldine Lottie Peaker</u>				4. DATE OF DEATH Month Day Year <u>7 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charlie Beasley</u>				14. MOTHER'S MAIDEN NAME <u>Laura Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-0069</u>		17. INFORMANT <u>Lottie C. Peaker</u>		Address <u>Singer Rd. Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AORTIC INSUFFICIENCY AND</u> DUE TO (c) <u>HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> <u>OVER 4 YRS</u> <u>OVER 4 YRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1956</u> to <u>JULY 6, 1960</u> , that (I) (we) last saw the deceased alive on <u>JUNE 30, 1960</u> , and that death occurred at <u>5:18 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip W. Heuman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>JULY 6, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>				22d. ADDRESS <u>307 Hickory, BEL AIR, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 11, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.,</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard McCombs</u>				ADDRESS <u>Abingdon, Maryland.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8078

CERTIFICATE OF DEATH

Reg. Dist. No. 8054

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Forest Hill		c. LENGTH OF STAY IN 1b Entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Forest Hill		d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last ROSE GRAFTON PYLE				4. DATE OF DEATH Month Day Year July 24 24 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1871	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McCommons				14. MOTHER'S MAIDEN NAME Jane Grafton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Walter Pyle		Address Forest Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1952, to July 24, 1960, that I last saw the deceased alive on July 11, 1960, and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Willard P. Hudson</i> M.D.				ADDRESS (Street, city or town, state) Forest Hill, Md.		DATE SIGNED 7/24/60	
PHYSICIAN'S NAME (Type) Willard P. Hudson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27/1960		22c. NAME OF CEMETERY OR CREMATORY Green Creek Methodist		22d. LOCATION (City, town, or county) (State) Forest Hill Harford Co. Md. (Rural)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Foster</i>				ADDRESS Bel Air Md		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
				24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

8062

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18055

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace 19 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2115 Union Ave</u>		d. STREET ADDRESS <u>2115 Union Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cornelia</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Percy Gause</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Connor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>W. Collins Thomas</u>		Address <u>211 S. Union Ave, Harre de Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to Drowning</u> DUE TO (b) <u>975X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>975X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned self in tub</u>	
20c. TIME OF INJURY Month, Day, Year <u>10</u> <u>27-22</u> <u>1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harre de Grace Harford md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Donald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Harre de Grace, Md</u>		24a. REC'D BY REGISTRAR <u>JUL 26 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

STATE OF TEXAS
COUNTY OF _____

BEFORE ME, the undersigned authority, on this _____ day of _____, 20____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20____.

Notary Public in and for the State of Texas

My commission expires this _____ day of _____, 20____.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8047

CERTIFICATE OF DEATH

Reg. Dist. No.

08056

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>				c. LENGTH OF STAY IN 1b <u>45 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EAST Broadway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>Thomson</u> Last <u>Thomson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER Thomson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Mach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-8137</u>		17. INFORMANT Address <u>430 E. Broadway</u> <u>Mrs. Sophie Sterstotter Thomson BEL AIR, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO <u>153.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma sigmoid &</u> DUE TO <u>regional metastases</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8, 1960</u> to <u>July 10, 1960</u> , that I last saw the deceased alive on <u>July 8, 1960</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.				ADDRESS (Street, city or town, state) <u>BEL AIR, Md</u>		DATE SIGNED <u>7/11/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR <u>12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8063

CERTIFICATE OF DEATH

Reg. Dist. No.

08057

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		d. STREET ADDRESS <i>1519 Alliance St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>519 Alliance St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Hannah</i> Middle <i>Hoke</i> Last <i>Turner</i>		4. DATE OF DEATH Month <i>7</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 10, 1899</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months <i>10</i> Days <i>19</i>	
IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Nathaniel Leggar</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Miller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-244109</i>	
INFORMANT Address <i>Mrs. Olivia Barrett, Bal-Air, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>443 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive-Arteriosclerotic Heart disease</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <i></i> at work <i></i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/20</i> , 19 <i>60</i> , to <i>7/28</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/28</i> , 19 <i>60</i> , and that death occurred at <i>6:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution Street</i> DATE SIGNED <i>7/29/60</i> ACTUAL SIGNATURE <i>George T. Stansbury</i> M.D. <i>George T. Stansbury</i> PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i> <i>Harre de Grace, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-1-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stellie J. Bullock</i>		ADDRESS <i>556 Lewis St.</i> 24a. REC'D BY REGISTRAR <i>AUG 2 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kious</i>	

BP

1. The first of these is the fact that the
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08058

8079

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITEFORD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITEFORD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John R. VAN HART</u>				4. DATE OF DEATH <u>July 16 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 24, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW PARK, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILBUR VAN HART</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ALMOKEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>204-05-3871</u>		17. INFORMANT <u>HATTIE VAN HART, WHITEFORD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.1 CORONARY OCCLUSION</u> DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 July, 1960</u> , to <u>16 July, 1960</u> , that I last saw the deceased alive on <u>15 July, 1960</u> , and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. A.E. Moseley, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>JARRETTSVILLE, MD.</u> DATE SIGNED <u>16 July 1960</u>			
PHYSICIAN'S NAME (Type) <u>Thos. A.E. MOSELEY, JR. MD.</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAWN GROVE METH.</u>		22d. LOCATION (City, town, or county) (State) <u>FAWN GROVE, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harbina, Delta, Pa.</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Physician

Attending Physician

Signature

Witness

Registrar

Official Seal



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU ONE 10

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bertha Jackson Westcott</i>		4. DATE OF DEATH Month Day Year <i>July 15 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 20, 1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>Jenkins Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Walton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-4352</i>	
17. INFORMANT <i>Samuel G. Westcott</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>? years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 10th 1960</i> to <i>July 15, 1960</i> that (I) (we) last saw the deceased alive on <i>July 15, 1960</i> and that death occurred on <i>7:00 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Loo</i> M.D.		22b. DATE SIGNED <i>7/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, MD</i>		22d. ADDRESS <i>Harre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/18/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mountain Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Joppa, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Tarring</i> ADDRESS <i>Tarring Funeral Home Aberdeen, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 20 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Hanna</i>			

1895

1895

CERTIFICATE OF DEATH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

[Faint text at the bottom of the page, possibly a signature line or official stamp area.]

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
8065 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08060

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>43 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy "B" Winn</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male Negro</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert M. Winn</u>		14. MOTHER'S MAIDEN NAME <u>Janet M. Coale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Winn Gen. Del. #40 Harre-de-Grace</u>		Address <u>Swan Creek</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 780.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anoxia & Prematurity</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/5</u> 19 <u>60</u> , to <u>7/7</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> 19 <u>60</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>7/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Harre-de-Grace, Md.</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>July 7, 1960</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem. Hsp.</u>		23d. LOCATION (City, town, or county) (State) <u>Harre-de-Grace, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. [unclear] Administrator</u>		25a. REC'D BY REGISTRAR <u>JUL 15 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. [unclear]</u>			

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8066

08061

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shore de Bruce</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanford Mem. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville, md</u> d. STREET ADDRESS <u>07X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>M. Virginia</u> Middle <u>Harriet</u> Last <u>Wychgram</u> 4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 5, 1905</u> 9. AGE (In years last birthday) <u>54</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Thomas M. Chamberlain</u>		14. MOTHER'S MAIDEN NAME <u>Annabelle Campbell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>220-22-0865</u> 17. INFORMANT <u>William Wychgram, Perryville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion -</u> (b) <u>Arteriosclerosis -</u> (c) <u>Nephritis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 6 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis - 20 yrs ago</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 4 - 1960</u> to <u>July 6, 1960</u> that (I) (we) last saw the deceased alive on <u>July 6, 1960</u> and that death occurred on <u>July 6, 1960</u> at <u>9:15 A.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.		22b. ADDRESS <u>Port Deposit, Md.</u>		22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-9-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Vee A. Patterson</u> ADDRESS <u>Perryville, Md.</u>					
25a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>					

8008

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
OFFICE OF VITAL RECORDS AND STATISTICS
CITY OF NEW YORK

(M)

(1)